IDAHO DEPARTMENT OF HEALTH & WELFARE

SUBSTANCE USE DISORDERS NEWSLETTER

April 2013

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Photo by Julie Ellsworth

RITE-TTI WORK CONTINUES

By Jon Meyer

Many of you may have heard a little bit already about the RITE-TTI grant and the different opportunities that we are working on in the Division of Behavioral Health as part of the project. This has evolved quite a bit recently so I thought I'd take a moment to walk you through the different aspects of what we're working on.

Peer Specialists: We are very happy to announce we have hired two Certified Peer Specialists that will help us facilitate the RITE-TTI (Recovery Infrastructure Training for Empowerment Transformation Transfer Initiative) activities. Bobbi Blankenship started on March 18 and will work 26 hours per week from our Central Office location in Boise. Kathy Blamires started on March 25 and will work 20 hours per week from the Twin Falls regional office. Both Bobbi and Kathy bring a lot of experience to this project and we're thrilled to have them on board.

Recovery Coach Training: We are providing the opportunity for Recovery Coach training on May 20th through May 24th at the Nazareth Center in Boise. A total of 50 individuals will attend this initial training, with an emphasis on recruiting those with personal experience with the recovery process. Of the 50 participants, 15 people will receive additional instruction through May 25th to become Recovery Coach Trainers. These 15 people will be able to provide Recovery Coach trainings in the future and ensure the sustainability of this project in Idaho.

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Each region has been allocated a number of slots to fill for the training, based on population. The decisions about who fills each open Recovery Coach slot will be made by the regional advisory boards. Regional Managers have been asked to designate full-time state employees to train as trainers. We will also be training two central office employees as trainers, as well as one person from the Idaho Supreme Court (which oversees the state drug court program), one from the Department of Correction, one from each of the two state hospitals, and two community members.

Trauma Informed Care Web Portal: With a wealth of useful information available on trauma informed care, we have set a goal of creating more than just a basic toolkit for Idaho. Instead, we're aiming to build a web portal that can be a living, growing and user friendly resource for both providers and consumers. We will form a group of subject matter experts to help guide the development of the portal, and reach out to stakeholders across the state for input on what should be included and how to make it the most accessible. This will allow us to open an ongoing dialogue with providers and consumers that will allow them to continually submit ideas and materials to enhance the portal's resources.

Action Plan Toolkit: We've set big goals for Recovery Coach training and development of the web portal, and we feel it is necessary to develop action plans to ensure the ongoing effectiveness of these projects. The goal in building these action plans will be to maximize the two projects for the benefit of Idaho. In developing these action plans, we want to ensure that Recovery Coach training continues far beyond the 50 initially trained, and keep our web portal up to date and relevant to the people who utilize it.

We also hope to develop an action plan that will help guide integrated Regional Behavioral Health Boards that would be formed under legislation introduced during this year's legislative session. Though the legislation was not passed this year, we still want to move toward the goal of an integrated Behavioral Health System of Care and this action plan could help us on that path.

IDAHO CAN BENEFIT FROM LESSONS LEARNED IN OTHER STATES

By Kathy Skippen

I am writing this article on my way home from a NASADAD (National Association of State Alcohol and Drug Abuse Directors) Board meeting. I have once again seen it clearly demonstrated that every state is approaching substance use disorder (SUD) treatment and prevention, use of the block grant, use of Medicaid and certainly the Affordable Care Act (ACA) differently. It is also clearly demonstrated to me every time that — as moderate as I think I am when it comes to government policy — I am still a conservative in comparison to my fellow board members. One of the strengths of the board is the broad spectrum of views held by the membership, and generally the other states are ahead of us in development of policy, so it is always a learning experience. The positive side of this is that hopefully we can learn from the steps and missteps they have made in the use of Medicaid and the building of their systems within the framework of the ACA.

There was considerable discussion at this meeting around health homes.

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In most places health homes are being created within a primary care atmosphere. The common experience is that most primary care providers have little understanding of the impact behavioral health issues have on their patients, and also are unaware of the ramifications on their ability to establish good outcomes with those patients. Educating primary health care providers to the liabilities of not adequately screening their patients for behavioral health issues, and developing resources within their health homes to provide for the array of services from brief interventions to treatment that will be needed, must be done. The states that are well down this road are seeing health homes with relatively low success rates when they haven't built in a component to deal with patients needing behavioral health services.

Another concern brought up deals with a lack of understanding on the part of prescribers to the problems of over-prescribing opiate-based medications. A number of states discussed the data they are collecting on clients who became addicted to the use of these prescription medications and then moved to illicit drugs because they are easier to acquire and cheaper to buy.

What this means, I believe, is that all of us (state agencies, associations, providers, consumers, interested community organizations) need to be taking the opportunities afforded us to educate those in primary health care on the costs, both monetary and human, to not understanding and then treating behavioral health issues with their patients. Decisions currently being made at all levels, whether made by SUD providers, mental health workers, local doctors, health insurance carriers or state agencies, will have an impact on what our future healthcare system will look like. We can hopefully benefit from the difficult lessons being learned in other states in how we go forward in Idaho.

THE IMPORTANCE OF CONTINUING CARE AFTER RESIDENTIAL TREATMENT

By Business Psychology Associates

Residential treatment is appropriate and often, in and of itself, effective as a long term treatment model for substance abuse disorders. The treatment goal is to achieve clean, sober living as well as psychosocial rehabilitation.[1] Much focus is often placed on residential treatment as *the* rehabilitating factor for individuals within the correctional system. However, it should merely be considered *an initial step* in the process of rehabilitation and disease management for substance abuse disorders.

The period following completion of a residential treatment program is a sensitive time for patients as they are re-entering their family groups, peer groups, and the stress of life, putting them at the greatest risk for relapse. Relapse may occur from a variety of triggers including peer pressure, stress, craving and withdrawal symptoms, or as a result from the patient's emotional state or motivation level. It is important to note that relapse should be used as an opportunity for teaching as it is actually a common part of the recovery process.[2] Regardless, the repercussions of relapse when not part of a managed care program often lead to the repeat of the cycle of substance abuse and consequently crime.

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When the treatment of substance use disorders and addiction is considered chronic disease management, relapse prevention is addressed by identifying personal, psychological, and environmental risk factors as part of a second phase of treatment.

The second phase of treatment, often identified as outpatient treatment, or continuing care, is recommended by most SUD treatment providers as a way to continue with the success that was gained during residential treatment. There are a variety of outpatient treatment options and deciding which one, or combination, should be directed by physicians and other mental health professionals. Consideration should be made as to the patient's coping style, social resources, and other risk factors for relapse.

Avenues for Continued Care

Case Management

Case management can be in the form of Recovery Management Checkups (RMC) where follow-up with patients includes ongoing contact, evaluation, and providing additional support services on an ongoing basis. Research shows that adolescents and adults who receive RMC's demonstrate higher levels of treatment participation, higher abstinence rates, and reduced time for readmission following relapse.

Self-Help and Peer Support Groups

Groups such as Alcoholics Anonymous and Alateen can be effective following residential treatment as they can provide new friends and peers with common goals, including those celebrating sober living. In addition, support for coping with stress and relapse-triggers is also provided.

Auxiliary Support Services

Assisting patients with support services available in the form of healthcare, job placement assistance, child care, or services for the homeless can help reduce relapse by easing the strain of anxiety in coping with these issues. Studies have also suggested that helping patients with auxiliary services can decrease the severity of their substance abuse. [3]

Sources:

[1] ***Treatment of Adolescents with Substance Use Disorders*, Treatment Improvement Protocol Series Section 3, US Dept. of Health and Human Services, 2008 (p 24)**

[2] ***Addiction Medicine: Closing the Gap between Science and Practice,* from The National Center on Addiction and Substance Abuse at Columbia University, June 2012 (p 107)**

[3] ***Addiction Medicine: Closing the Gap between Science and Practice,* from The National Center on Addiction and Substance Abuse at Columbia University, June 2012 (pg 108)**

THE PREVENTION WORKGROUPS HAVE BEEN WORKING!

By Office of Drug Policy

During the spring and summer of 2012, the Office of Drug Policy formed workgroups to address the top three substance abuse prevention concerns in the state as identified by the data: underage drinking, marijuana use, and prescription drug abuse. Made up of representatives from diverse community sectors around the state, these workgroups have made great progress in analyzing the issues, setting goals, and preparing strategic action plans with Idaho-specific strategies to reduce substance abuse.

By far the number one substance abuse issue currently facing Idaho is underage drinking. Years of societal acceptance of youth drinking have created a social norm throughout our state that this is simply a "rite of passage." In response, the workgroup will be working to reduce accessibility to minors, reduce demand for alcohol by minors, and increase the perception of risk associated with underage drinking to reach their goals of reducing past 30 day usage and increase age of onset.

While most drug use statistics reflect a decline in use over the past several years, marijuana use has grown. This is likely due to the "medicalizing" of the drug currently experienced in our society. Idaho is nearly surrounded by states that have legalized marijuana use for medical purposes, and this issue is being debated around the country. To address these concerns, the marijuana workgroup will work to reduce accessibility, reduce demand, and increase perception of risk associated with marijuana in an effort to reduce past 30 day usage by Idaho students and reduce lifetime usage by youth.

Perhaps one of the most alarming trends in substance abuse today is that of prescription drug abuse. According to results from the 2010 National Survey on Drug Use and Health (NSDUH), an estimated 2.4 million Americans used prescription drugs non-medically for the first time within the past year. This equates to approximately 6,600 new abusers per day. Clearly, this epidemic is growing at an extreme rate. To counter this epidemic, the prescription drug workgroup is striving to reduce the number of prescription drug related deaths in Idaho by increasing the use of the Prescription Monitoring Program (PMP); educating prescribers regarding the signs, symptoms, and dangers of prescription drug misuse and abuse; identifying the gaps in the data and taking measures to eliminate those gaps; and identifying issues which make enforcement and prosecution of prescription drug related crimes difficult and taking steps to minimize or eradicate these issues. The workgroup is also working to reduce the number of Idaho students reporting that they have taken a prescription drug without a physician's prescription by implementing an educational campaign designed to inform Idaho youth and adults regarding the devastating consequences of prescription drug misuse and abuse.

The plans prepared by these groups are now being compiled to form the Idaho State Prevention Plan which will guide the Office of Drug Policy's future prevention work. This is a living document that the workgroups will continue to revise as the data and needs of the state change. We appreciate the commitment displayed by everyone involved in these efforts and applaud their commitment to making Idaho a safer, healthier place to live.

WITS IMPLEMENTATION UPDATE

By Denise Williams

Thirty-two provider agencies have been trained to use WITS. These provider agencies are in various stages of implementation. Various reports aimed at assessing provider progress show increased success in the use of WITS.

Phase 2 implementation started March 25th and will continue in April. Phase 3 implementation starts on April 22nd and there are still openings for providers to sign up to participate in Phase 3. To sign up, providers should utilize the calendar located at www.WITS.dhw.idaho.gov.

The multiple training dates are meant to allow flexibility by providing different opportunities to obtain the core trainings at different times. Providers do not need to attend every date noted for the training topic. Choose one training date for each type of core training.

In addition to the trainings, there are conference calls available to all provider agencies, such as the Staff Readiness and Open Q & A meetings. These calls are available to all provider agencies, and are especially important to provider agencies choosing a self-guided implementation approach.

The Department will continue to post implementation information and guidance on the website so check back to keep informed and access the latest news about WITS.

WITS and GAIN Information Source

The Department's website makes lots of information available to providers. This information is located at www.WITS.dhw.idaho.gov.

WITS User Guides are available to all providers. For those providers choosing to do the self-guided track of WITS implementation, the WITS User Guides will be instrumental in learning how to implement WITS in your agency. GAIN training materials are also located here for provider use. Current security forms for WITS and GAIN can be accessed, as well as trainee forms.

WITS Help Desk

The Department of Health and Welfare Central Office continues to support providers through the WITS Help Desk. The WITS Help Desk can be contacted by calling 208.332.7316 or by emailing DBHWITSHD@dhw.idaho.gov. WITS Help Desk support is available to answer calls Monday through Friday, 8 a.m. to 5 p.m. MST.

IDAPA RULE CHANGES

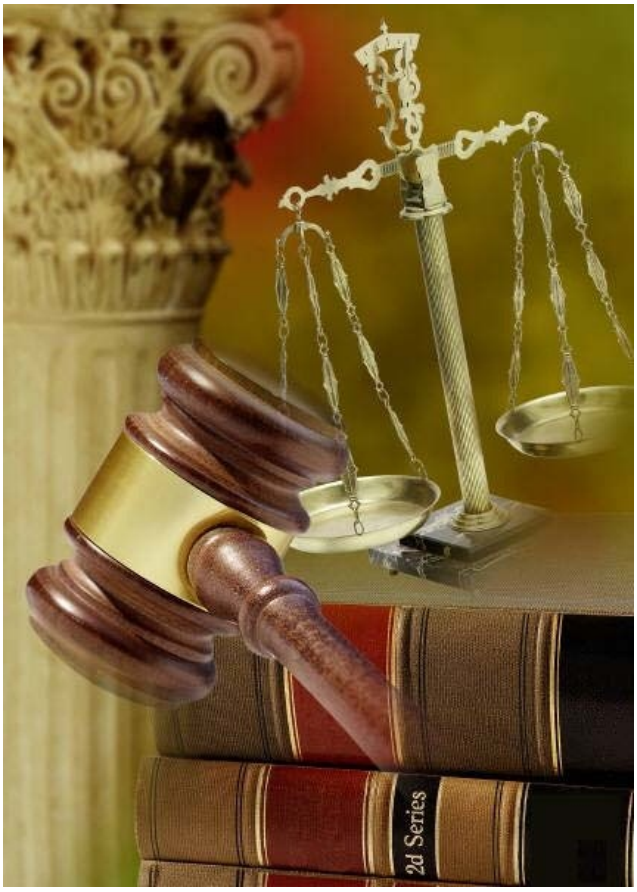
By Treena Clark and Ryan Phillips

Proposed changes to IDAPA rules were reviewed by the House Health and Welfare Committee on January 21 and 22, 2013, and by the Senate Health and Welfare Committee on January 23, 2013. Following is a link to the website to review the minutes:
http://legislature.idaho.gov/sessioninfo/2013/standingcommittees/committeeminutes.htm
The new rules have been adopted and, with the exception of changes to the Criminal History and Background Checks, will go into effect July 1, 2013. Until July 1, 2013, all current IDAPA rules are in place. The dockets reviewed and adopted by the Legislature are published in the 2013 Legislative Rules Review Books. The Legislative Books are available on the Idaho Department of Administration website at:
http://adminrules.idaho.gov/legislative_books/2013/index.html
Click on the Health and Welfare Committee link.

- Docket No. 16-0720-1201 Alcohol and SUD Treatment and RSS Facilities and Programs
- Docket No. 16-0608-1201 DUI Evaluators
- Docket No. 16-0701-1201 Behavioral Health Sliding Fee Schedules
- Docket No. 16-0717-1201 Alcohol and Substance Use Disorder Services

Changes in the rules include:

IDAPA 16.07.20 "Alcohol and Substance Use Disorders Treatment and Recovery Support Services Facilities and Programs"



- Licensed clinicians seeking status as a Qualified Substance Use Disorders Professional will no longer be required to demonstrate 1,040 hours of supervised SUD experience.
- Separate Learning and Intensive Supervision plans will no longer be required. Instead, the clinical supervision record must contain a Professional Learning Plan, as defined in the new rules.
- Separate plans will no longer be required for treatment, case management, co-occurring disorders, and discharge planning. Instead, the new rules will outline a comprehensive service plan intended to consolidate and simplify the process for both clinicians and clients.
- Clinicians will no longer be required to justify continued stay or summarize medical conditions in each progress note.

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16.06.08 "Rules and Minimum Standards for DUI Evaluators"

- This chapter of rule is being repealed. There will no longer be a separate licensing process for DUI Evaluators.

Providers are encouraged to review and be aware of all changes to IDAPA 16.07.20. A crosswalk of these changes, as well as information on the DUI Chapter repeal, can be found on the DHW website at: http://healthandwelfare.idaho.gov/Medical/SubstanceUseDisorders/tabid/105/Default.aspx

CRIMINAL HISTORY AND BACKGROUND CHECK RULE RE-WRITE

During the presentation of the rules, DBH requested that the House and Senate Health and Welfare Committees reject changes to the Criminal History and Background Checks (IDAPA 16.07.20 Section 009). This section affects providers who are in recovery themselves, unable to pass background checks due to previous criminal convictions, but are valuable role models and mentors. The impact of rejecting this section of the proposed rule change is that it will continue to allow providers who could not pass the background check but who were already working in SUD treatment prior to May 2010 to continue employment as a SUD treatment provider. The intent of rejecting the change is to allow individuals to remain grandfathered under the current rule while DBH works with providers to develop a rule that fits Idaho's model of recovery.

DBH is currently working on building a peer recovery system and one of the issues that has come up as a barrier in Idaho is the requirements around background checks. The current requirement does not work for the services that are being provided and it does not fit the model of recovery services that DBH is promoting. DBH has also received complaints from SUD treatment providers regarding the current rule as it negatively impacts their workforce and ability to provide treatment services.

DBH will be working with providers and other interested parties to develop a Background Check and Criminal History rule that both protects the client and acknowledges those who are successful in their recovery by allowing them to work in the treatment field. Negotiated Rule Making meetings on changing the rule have been scheduled for:

Monday April 22nd
12:30pm—2:30pm (PST)
1:30pm—3:30pm (MST)

Wednesday April 24th
1:00pm—3:00pm (PST)
2:00pm—4:00pm (MST)

Individuals will be able to participate via video conferencing at their local Regional office or by telephone conferencing. Details for the meetings will be sent out in a separate communication. If you have comments, suggestions or ideas regarding the rule change, please send them at any time to Treena Clark at ClarkT@dhw.idaho.gov.

MEET THE PROVIDER: PORT OF HOPE

By Jon Meyer

Over the past four decades, the brick-and-mortar of Port of Hope's alcohol and substance use treatment programs may have changed significantly, but the goal remains the same: To give men and women the tools they need to guide themselves to lasting recovery.

Beginning in 1971 as a sober living environment in Twin Falls, Port of Hope grew to include, at one point, more than 20 outpatient substance use treatment centers located around the Gem State.

Today, Port of Hope services are consolidated in two locations in Nampa and Coeur d' Alene. Staff are committed to working with clients compassionately on an individualized basis, helping them through their specific issues and challenges, and meeting them with empathy.

"Through the group process and individual counseling we're able to address our clients' individual needs like guilt and shame, grief and loss, self-esteem, and unhealthy relationships," JoLynn Tracy, director of the Nampa center, said. "Clients tell us those are some of the driving forces that keep them using."

Port of Hope's two centers offer services that include drug and alcohol assessments, DUI evaluations, individual and group counseling, educational services, cognitive self-change and moral reconation therapy classes, outpatient services, social model detox and residential treatment.

The residential treatment centers are each staffed 24/7, with about 20 staff and up to 15 spaces for clients. Each center has social model detox beds available, and substance use disorder treatment clinicians who also serve as certified case managers.

Starting as an outpatient counselor for Port of Hope about 10-and-a-half years ago, JoLynn moved on to become a residential counselor and then clinical coordinator, before taking on her current position as director of the Nampa facility about five years ago.

The feeling of watching clients change and grow still makes her happy. "It is very rewarding to myself and the other staff at Port of Hope when former clients contact us to thank us for helping them to get their lives on track and to let us know how they are being successful in their recovery," JoLynn said. "We always invite those alumni back to share their experience, strength and hope to those just starting the journey."

Regional Resources

Region 1

www.rac1.dhw.idaho.gov

Community Resource Development Specialist

Corinne Johnson 208.665.8817

Region 2

www.rac2.dhw.idaho.gov

Community Resource Development Specialist

Darrell Keim 208.882.6932

Region 3

www.rac3.dhw.idaho.gov

Community Resource Development Specialist

Joy Husmann 208.455.7108

Region 4

www.rac4.dhw.idaho.gov

Community Resource Development Specialist

Laura Thomas 208.334.6866

Region 5

www.rac5.dhw.idaho.gov

Community Resource Development Specialist

Beth Cothern 208.732.1582

Region 6

www.rac6.dhw.idaho.gov

Community Resource Development Specialist

Brenda Price 208.234.7929 or 208.705.9145

Region 7

www.rac7.dhw.idaho.gov

Community Resource Development Specialist

Brenda Price 208.234.7929 or 208.705.9145

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